State Responses to CON Monitoring Questions

On April 4, 2006, the inquiry below was emailed to each of the 37 Certificate of Need program directors in the country. As of April 29, responses have been received from 22 agencies as depicted in this final compilation (minor editing was done to improve readability; however, no changes were made to the intent).

> *I'm currently assembling perspectives on the relationship of CON compliance efforts, data resources and communication . . . could you briefly describe for me:*
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> 1. *The dimensions of your CON compliance efforts like type of follow-up, period of oversight and penalties for non-compliance? Any feedback of compliance back into your state health plan (or criteria and standards, if no plan)?*
> 2. *What inventory and utilization data systems are available for your use in analyzing CON applications?*
> 3. *What ongoing communication do you have with licensing, reimbursement and other state agencies about CON issues?*

The compiled responses are listed below alphabetically by state with the columns arranged across in the order of the questions posed above.

State (respondent)	**Dimensions of compliance efforts by Certificate of Need agencies**	**Feedback to state health plan**	**Inventory and utilization data systems for CON reviews**	**Communication with other state agencies about CON**
Alabama (Paul May)	Agency follows up every six months after issuance of certificate of need until project is completed. If project has cost overruns of 10% or greater, the applicant must pay a cost overrun fee of 10% of the overrun and the filing of a certificate of need application. Through the review of annual report from health care facilities, the number of beds and services provided are verified for certificate of need compliance.	(no response)	The number of beds, occupancy rates, average daily census, financial information, costs, revenue, equipment, and census, including race breakdowns and utilization factors. We also conduct a Patient Origin Survey four times a year on hospital inpatients.	We send copies of reviewability determinations, notices of changes of ownership, and certificates of need to the Department of Public Health (licensing entity), Blue Cross/Blue Shield of Alabama and, when applicable, to Alabama Medicaid Agency and Department of Mental Health and Mental Retardation. Also, when applicable, we provide a copy of the review schedule and certificate of need application to the Medicaid Agency and Mental Health Department.
Alaska (David Pierce)	The main penalties for non-compliance are: 1) injunction can be filed; 2) Medicaid payments withheld. We do have a follow-up clause in our CON process to allow staff to do a site visit on the project.	(no response)	We are implementing a new utilization data system that covers all types of services reviewed under CON. It will eventually have all of the latest annual data and will be published on the web. All facilities are required to participate.	We work closely with all of the agencies mentioned in the question, and regularly coordinate our efforts including being sure CON is mentioned in the other agencies regulations where needed.
Arkansas (Mary Brizzi)	Our Rules allow nine months from the date the CON (Permit of Authority) is issued to sign a construction contract, six months from that point to complete the foundation and 12 months from that point to apply for licensure on the project. If any of those deadlines will not be met, an extension can be requested. The Commission can grant an extension of up to six months at any of the deadlines. Our POA compliance efforts consist of letters that are sent prior to the deadlines. If an extension is not requested or granted, the Permit of Approval is subject to termination.	(no response)	Utilization data for nursing homes and assisted living facilities is available from The Office of Long Term Care at the Department of Health and Human Services. We administer a survey to psychiatric residential treatment facilities, hospices and home health agencies to get utilization data. We also use national cost-per-day data about hospice and home health in the application review process.	There are open lines of communication with some of the licensing agencies, especially The Office of Long Term Care. When a license changes, those changes are automatically sent to this office. The psychiatric residential treatment facility licensing entity does not communicate with our office. We have to contact them if we need information. All licensing agencies are willing to share information with us. The Medicaid office is also willing to share information, if it is requested, like the figures for nursing homes.

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Connecticut (Susan Cole-England, CON director, and Karen Roberts, Compliance Officer for the Connecticut Office of Health Care Access who provides the oversight for the post-CON monitoring and compliance function)	The majority of CON authorizations that are approved have conditions or stipulations attached (such as the project has to be completed by a certain date, the applicant must file certain post-CON documents by a certain date, some have either permanent or temporary statistical utilization reporting, etc). These conditions are project-specific (i.e., the CON expiration date is not, for example, two years for all approved projects, but is based on the project's specific facts). The setting of conditions in the approval is not set forth in statute or regulation. If material or reporting is due, but not yet filed, I would send that applicant a compliance letter to find out project status and up date our records. If an Applicant needs a time extension, cost overrun or change in a condition or stipulation, that applicant may file a modification request which will be reviewed by me and acted upon by the Commissioner of Office of Health Care Access OHCA (allowed by Section 4-181(a)(b) of CT statutes). A modification can be denied or a CON authorization can be determined to be expired if the project is not completed in a timely manner (unless for good cause), in which case that applicant would need to file a new CON to do the project. We have no specific regulations regarding the modification process. Other than a CON possibly being deemed expired or null and void, OHCA's statutes also allow the possibility of implementing a civil penalty or late or missing data (Section 19a-653 of the CT statutes) or even OHCA's refusal to accept a new LOI or CON if any material which is due to OHCA (i.e., utilization statistics) is late or incomplete (Section 19a-639e of CT statutes).	(no response)	OHCA has a discharge data base that provides detailed information about inpatient utilization of the Connecticut acute care hospitals. We also have detailed financial filings of each of the acute care hospitals. We are in the process of developing a cardiac database as well.	Facility licenses cannot be issued by the Department of Public Health without proof of CON authorization. Exemptions from the CON process may be requested by state agencies that provide grant funding for the programs. These agencies include the Department of Mental Health and Addiction Services, Department of Children and Families and the Courts.
Florida (Jeffrey Gregg)	Compliance occurs in two phases. The first is compliance related to the implementation of the CON. This is generally much less intense than in earlier eras of the program, in part because there is no longer any regulation of cost overruns. Very occasionally, projects cannot be implemented in the required timeframe and the CON is forfeited. CONs are good for 12 months with a relatively easy 6-month extension. Additional 60-day extensions can be granted in rare cases, normally because of local zoning issues. The more significant and ongoing aspect of compliance relates to the conditions that we place on the CONs. These typically relate to promises to deliver certain amounts of uncompensated and/or Medicaid care. There is a process to modify CON conditions based on good cause due to changing market conditions etc. Fines have been on the increase in recent years. The greatest was approximately $1.3 million spread over a couple of years.	(no response)	The CON program maintains inventories and has authority to get needed utilization information from the 3 types of facilities that are regulated by the program.	We are all located in the same Agency. The size and scope of our CON program has steadily trended downward and my bureau includes both CON, as well as licensure units for the regulated types of facilities. Relatively speaking, I would say that our communication is close.
Hawaii (David Sakamoto)	Our statute/rules require that progress be made within a year. For some projects that's sufficient in our opinion. For others it's not. The CON recipient sends documentation of progress (which can be fairly minimal) within a year. We do have a simple tickler system.	(no response)	We collect utilization data from providers annually and have the info on our website.	We have a positive and crucial relationship with our licensing colleagues (Office of Healthcare Quality Assurance), and they assist in monitoring the conditions we set, when appropriate.
Kentucky (Shane O'Donley)	Once their CON is approved, the applicant must document their progress towards implementing their project by submitting regular progress reports. If these reports are not submitted, or an extension is not justified, the certificate may be revoked. If revoked, the Cabinet's Facilities and Services Inventory is updated appropriately.	(no response)	The Office of Health Policy collects and publishes annual reports containing all utilization data for CON covered services. CON decisions are based on the most recently published utilization report at the time of the decision.	We solicit involvement from the following agencies when annually updating our State Health Plan: Inspector General, Medicaid, Public Health, Mental Health and Mental Retardation, Office of Aging, Office of Health Policy, Commission for Children with Special

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				Health Care Needs, and Legal Services. We also maintain regular contact with the Inspector General when responding to advisory opinion requests and day-to-day operations.
Louisiana (James Taylor)	Currently, we have a moratorium on bed approvals for Nursing Homes and ICF/MRs. Medicaid bed approval is the only element of our system that looks like a CON. It really isn't a CON program. Compliance is restricted to rules on enrollment. If you dis-enroll or de-license your bed for 120 days without putting them into abeyance or an alternate use, then the bed approvals expire.	(no response)	Louisiana is not taking applications for new bed approvals because of the moratorium. We have a database of inventory of approved and licensed beds and we have an inventory of bed utilization the is published quarterly. The data is collected from the bed fee payments of Nursing homes and ICF/MRs.	Facility Need Review is under the licensing agency of the Department. Reimbursement is notified of any changes in the approved beds.
Maryland (Paul Parker)	All CON awardees are required to file quarterly reports beginning 3 months following CON award through project completion or other final disposition of the CON. The quarterly report format is specifically tailored to the project. Reporting of any changes in estimated project budgets and timing of project implementation are standard features of each report and, if conditions were placed on a CON, reporting on compliance with the conditions is also standard. (Cost increases beyond an inflation index ENR health facility) require Commission approval. Also, MD regs specify time requirements for completion of specific categories of project and some extensions of these time limits are allowable, by staff approval, and other time extensions are not. The only sanction available is withdrawal of the CON by the Commission if "project is not progressing satisfactorily" (the timing requirements) or the applicant "is not reasonably attempting to comply with conditions imposed."	The Commission has, in the past, proposed statutory authority for financial penalties (fines) as an additional sanction, given that withdrawing a CON is a long legal process that is not flexible enough. This effort was not successful. The thinking was that the ability to fine would be an appropriate sanction for motivating progress on project implementation or conditional compliance more suitable to the specific level of moderate lack of progress or compliance infraction, while the "nuclear option" of withdrawal was too big and costly to be useful except in the most egregious of cases.	Comprehensive hospital discharge data base (MD and DC routinely available) Hospital financial data base (used in rate setting by another state agency) - this includes some data fields covering use of outpatient services in the hospital Ambulatory surgery facility survey - capacity, use, financial Long-term care facility survey - capacity, use, financial	MHCC works closely with Health Services Cost Review Commission, which sets hospital rates. HSCRC provides a financial viability and feasibility opinion for all hospital CON applications. Monthly staff meetings to coordinate policy. Rate increase requests for capital projects are only reviewed by HSCRC if project has a CON. CON decisions can require HSCRC to adjust such rate increases to eliminate building cost or space deemed to be excessive in the CON review. MHCC coordinates with licensure agency, Office of Health Care Quality in DHMH, on all facilities regulated under CON. MHCC determines annual adjustment in maximum licensed acute care bed capacity in general acute care hospitals, based on changes in census reported through HSCRC discharge data base. MHCC participates with MD Institute for Emergency Medical Services in policy and standard setting for hospital ERs and with Maternal and child health divisions of DHMH in perinatal facilities standards setting. Payors can and do act as interested parties in CON review. CareFirst Blue Cross Blue Shield is a frequent interested party.
Massachusetts (Joan Gorga)	We have a very active compliance program. Applicants with changes to the project prior to implementation must file amendments which are categorized as immaterial, minor or significant. Minor or significant changes require public newspaper notice and give interested parties the right to comment on the amendment. These requirements cease at implementation. Also important are the changes of site and ownership of approved, but not yet implemented, projects. These also require public notice and give interested parties the right to comment.	Results of compliance activities are available at the time of the updating of standards and guidelines.	Since the Determination of Need (DoN) program is in the same Bureau as the licensing program, DoN has access to the licensing data although access requires a phone call. We also have access to reimbursement data through another division.	Our communications about licensing are the most active since we are part of the same Bureau. Plan review staff in the licensing program are conscientious about checking to ensure that the conditions of the DoN approval letter are followed precisely. Assistance from the reimbursement program is given freely and quickly when issues arise in a review.
Michigan (Larry Horvath)	**Follow up:** 1) 11-months after approval, see if project is 100% complete; 2) if not, require an enforcable contract that spells out start date for construction or equipment to be installed; 3) two years after approval, check to see if project is 100% complete, construction started, equipment installed; and 4) if project is not 100% and construction is started within two years, next follow-up date is targeted completion date in application. **Follow-up documentation required:**	As for compliance, this is a mixed bag. We do monitor CONs to determine if they are completed or not, but do limited enforcement of volume requirements, etc. We mostly enforce volume requirements through the application process. If an entity is not meeting	1) The Michigan Inpatient Data Base (MIDB) includes primarily all hospital discharges in Michigan. It is purchased by the Department annually from the Michigan Health and Hospital Association. It is used to determine need for open heart, cardiac cath, hospital beds, NICU beds, lithotripsy, etc. 2004 is the most current MIDB data available. 2) The MRI Utilization Data Base was created and is maintained by the Department. All	1) all CON approvals are copied to other applicable state agencies, including finance authority, environmental quality, Medicaid reimbursement, and licensing authorities 2) CON is located within the bureau that also contains licensing and certification for health facilities, nursing home monitoring, engineering, radiation safety. Hold weekly meeting with Bureau director that including licensing, engineering and radiation safety.

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	1) copy of executed lease/purchase agreements; 2) copy of license; 3) copy of construction permit; 4) copy of radiation safety certificate; 5) final accounting of project costs and sources of funds; 6) vendor installation date; and 7) start of clinical operations and completion date of project. **Penalties:** 1) expire or revoke CON for noncompliance; and 2) civil fines, quarterly reporting of data, charity care for noncompliance with volume requirements (recent compliance activity).	volumes, that entity would not be approved to expand or replace a service (what we call "soft" compliance). I have been with the program for a little more than three years and have had limited success with actual enforcement (lack of DCH administrative will to enforce standards). We have only been successful in enforcement when we find entities operating without a valid CON *- approximately four times in the past three years.	MR providers must submit quarterly to this system. Twice a year, the Department publishes a utilization list from this system that is used to demonstrate need and also for compliance. The MR providers report approximately 600,000 scans through this system annually. It is a highly complex system that redistributes excess volume back (by provider) to be secured by applicants. It is this tight surveillance monitoring system that helped Duke conclude in their study a few years back that Michigan has been able to control the growth of MR services when compared nationally. 2005 is the most current MR data available. 3) The Annual CON Hospital and Freestanding Questionnaire is the primary tool for compliance, and for other services, such as surgical, to demonstrate need. The paper survey was replaced by an electronic survey this year. We are currently working with a contractor to create a web-based survey that should improve turnaround time. 2004 is the most current survey data available. We do some rudimentary checks on the data, but for the most part it is self-reported. We plan to conduct data audits once our enforcement program is in full swing.	Fire safety is coordinated through our engineering section. In addition, these other authorities have access to the online CON management information system (web-based). Communication very good!!!
Mississippi (Rachel Pittman)	Progress reports on all CON applications approved are due every six months and at completion of the project. If projects are not commenced within 12 months, or if continuous progress is not shown, the Department may revoke the CON after due process.	No, there is not.	The Department may use a variety of information in analyzing applications: State Health Plan, Patient Origin Studies, Report on Hospitals, Report on Institutions of Aged and Infirmed, etc.	The Division of Health Planning and Resource Development has daily communication with the Division of Health Facilities Licensure and Certification, and with other state agencies as needed.
Missouri (Tom Piper)	Progress reports are required by the applicant every six months after CON issuance until the project is operational. Project should have a capital expense by end of first year, but extensions are available. No fines, but the CON may be revoked for failure to submit progress reports or make a capital expenditure. . . cost overrun provisions are also available if project exceeds 10% of budget.	Experience from compliance is used to update and modify the CON Rules.	Data is provided quarterly through a cooperative effort with the Long-Term Care Section of the Department of Health and Senior Services. Hospital annual data comes from the Hospital Industry Data Institute. No outpatient data available.	Communication between CON, licensure and medical services (Medicaid) is frequent and direct between staff. A “round table” meeting is held after each CON meeting to communicate actions and exchange information affecting all above agencies. Web-based CON information systems.
Nebraska (Claire Titus)	The Nebraska Health Care Certificate of Need Act contains a violation section to deal with those facilities engaging in an activity identified as requiring a CON without first having a valid CON. (Neb. Rev. Stat. 71-5868) There is also a section in this Act that provides for revocation or suspension of the facility license for those violating the Act. (Neb. Rev. Stat. 71-5869). Note: I have been involved in the CON program since approximately 1997 and am not aware of any instances of facilities violating this act.	(no response)	The Certificate of Need program is part of Credentialing Division, Regulation and Licensure (R&L), Health and Human Services. Another Division within R&L is the Data Management Division which collects, maintains and provides utilization statistics for hospitals and nursing homes. Our contact person is Kathleen Korinek.	Certificate of Need and Licensure of hospitals and nursing homes are both done in the same division (Credentialing Division). CON is only required for long term care and rehabilitation beds, and there is a moratorium on both types. When we do get calls and letters asking about long term care beds and rehabilitation beds, communication is easily done for licensure and CON purposes. We just gather the appropriate people within our Division plus usually a person from Legal Services, which is also part of Health and Human Services, discuss the issue and write the letter. If reimbursement becomes an issue, this is done in another part of Health and Human Services so we just call them and meet if necessary.
Nevada (Lynn Solano)	Once a Letter of Approval has been issued, we require quarterly progress notes, detailing what has or has not	Nevada has no state health plan.	No inventory or utilization data systems are used at this time.	We currently provide the licensing agency with a copy of any concerns that will affect an

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	occurred with the project. Non-compliance could result in a Letter of Approval being withdrawn.			applicant's ability to license.
New Jersey (John Calabria)	Compliance is considered whether or not the approved CN applicant complies with the cost and scope of the project approved and whether or not the applicant has complied with any conditions placed on CN approval. Applicants are required to notify the Department of any changes in scope (changes that decrease scope in terms of number of beds generally do not require re-review unless this has a negative effect on access to care; changes that would increase beds/services are not permitted and, thus, would not be licensed). Conditions placed on CN approval become conditions of licensure and are monitored during surveys and/or by complaint. Violations of conditions are therefore licensure violations and subject to licensure penalty (including civil monetary penalties) and required denial of any future CNs filed by an applicant who has failed to implement conditions. At the time of CN approval, the applicant has an opportunity to reject conditions and the Department has the opportunity to then suspend the approval and rethink whether or not approval is warranted. In reality, no one ever contests a condition at that time -- usually it is some time later, although it doesn't happen too often.	There are quarterly meetings with the trade associations representing hospital, long term care/assisted living and home health/hospice providers. These have been ongoing for some years and feedback on all CN matters (including need methodologies and criteria) are often discussed at these meetings.	We have a full licensure database of all our licensed facilities; we have good utilization data for hospital and nursing home inpatient services. No ambulatory care services require CN approval in NJ, so our lack of good utilization data in these areas is not an issue in CN.	Acute care facility Licensing and all CN are located within the same unit (CN/ACL). A very recent reorganization has placed CN/ACL in the same division as Long Term Care Licensing. However, at all times, there has been constant communication with LTC Licensing.
Ohio (Christine Kenney)	We monitor approved CON projects through development and have oversight for a period of five years from project completion. Penalties for non-compliance include withdrawal of CON approval, refusal to accept an application from the applicant or related party for one to three years and a fine calculated as the greater of $3,000, 5% of the operating cost, or 2% of the capital cost, not to exceed $250,000.	(no response)	"Aspen" is used to identify the inventory of licensed and certified long-term care beds. The Medicaid cost report is used to identify utilization of long-term care beds.	We have daily communications with state licensing regarding authorization for licensure and compliance with licensure requirements for proposed projects. The Ohio Department of Job and Family Services (reimbursement) is copied on all CON approval and withdrawal letters. We also have discussions with reimbursement regarding the franchise fee.
Rhode Island (Mike Dexter)	We have stepped up our follow-up of conditions of approval, and surveyed all approvals from 2005, and have found a few cases where applicants needed change orders. As you might imagine, follow-up is staff intensive and, since we are essentially a 3-person office (Chief, analyst, secretary), just keeping up with the incoming applications is difficult, not to mention doing any follow-up. As far as penalties, we may have something to report regarding a failure to provide the specified amount of charity care -- too soon to tell yet.	(no response)	Just basic Excel spreadsheets.	Very active and ongoing communication with Medicaid, the Attorney General's Office, the Office of the Health Insurance Commissioner and other state agencies and, of course, the legislature.
South Carolina (Albert Whiteside)	South Carolina requires monthly reports on the progress of approved CONs until a valid signed construction contract and building permit are obtained. After the project is approved, the applicant must submit a final completion report that details the project, such as an audited cost report that shows all expenditures, a signed statement from a registered architect or engineer verifying final construction cost. Once the proposal is licensed, the CON is considered to be fulfilled. There are monetary penalties for failure to either stay within the approved dollar amount with some variance. There are also monetary fines for failing to file a CON or request an exemption from the CON program.	The only feedback mechanism is that we are all located in the same office and the compliance reports come to the staff person that actually works for me; so we all are on the same page as far as the completion of projects is concerned. When we are developing the health plan, we know what has gone on.	We collect the utilization data for all health care facilities; therefore, we know the inventory and utilization information. Health licensing is a part of the same area within our agency.	We meet weekly with licensing, the certification staff for Medicare and Medicaid, and our architect and engineers who review the actual construction documents of the applicants. We are all in the same state agency and building. We meet with the Medicaid reimbursement staff when needed. We coordinate the health plan that is used for CON decisions with other state agencies when the plan is being drafted.
Tennessee (Melanie Hill)	Annual progress reports until the project is complete. Once complete, the licensing agency is responsible for compliance (enforcing any condition placed upon the CON). Penalties are applicable if a CON was not obtained prior to initiating a covered service or establishing a health care institution. *68-11-1611. Review of progress –*	(no response)	We currently utilize a Microsoft Access database to track CONs. We now have a statistical analyst on staff to manage our equipment database. Once that is complete the analyst will develop additional data systems. The Department of Health collects data in TN	We meet monthly with the CON review section of the Department of Health and have frequent telephone communication with the licensing/certification section of the Department of Health. A representative of the licensure section attends our meetings as

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	Revocation of certificate * The agency shall, at least annually, review progress on any project covered by an issued certificate of need, and may require a showing by the holder of such certificate of substantial and timely progress to implement the project, and if, in the opinion of the executive director, such progress is lacking, the executive director may present a petition for revocation of the certificate of need for the agency's consideration. The agency may revoke the certificate of need based upon a finding that the holder has not proceeded to implement the project in a timely manner. [Acts 2002, ch. 780, § 4.] Effective Dates. Acts 2002, ch. 780 § 9. May 29, 2002. *68-11-1617. Violations * Penalties ** The agency has the power and authority, after notice and an opportunity for a hearing, to impose a civil monetary penalty against any person who performs, offers to perform, or holds such person out as performing any activity for which a certificate of need is required, without first obtaining a valid certificate of need.		through the Joint Annual Report system. This data is self-reported by health care institutions and is 1-2 years old. We would like to move to a claims database, but that will be a Department of Health decision.	frequently as possible to address any questions members may have regarding licensure issues. We also work with TennCare (TN Medicaid). The Director of TennCare sits on our board.
Vermont (Donna Jerry)	We require implementation reports every six months through a point where we deem the project to be substantially completed and occupied. Typically, this is one to two years, but the CON issued can contain conditions that require a longer period of implementation reporting. There are penalties for non-compliance including refusal to license or reimburse, and may result in civil action to prevent operation of the proposal.	The Health Resource Allocation Plan (HRAP) was implemented July 2005, and will not be updated for about two more years. Potentially any issues identified or lessons learned from implementation reports could be used when the HRAP is revised.	The HRAP provides an inventory and also specific standards that apply to various types of CON projects. We have 20 plus years of very detailed data on hospitals, and also refer to national benchmarks for some projects, hire consultants to assist in evaluating a project and/or conduct research. However, our CON program does not currently have its own set of benchmarks that apply to project types. We review each application on a case-by-case basis and consider the merits, or lack thereof, of each given the information and data that is provided and what we find in our research and analysis.	When a CON application is received, we send copies of the application and any interrogatories to the agencies and/or departments we identify in state government. We also follow-up with such agencies and departments for any input, insight or analysis they can provide during the course of our review of each application. One of the items that the staff report and CON Decision require us to address is the Position of the Agency of Human Services.
West Virginia (Dayle Stepp)	The Health Care Authority can condition an approval for a three-year period; revoke the CON; and impose monetary fines.	(no response)	State code requires financial and utilization reporting. Also, use surveys for utilization data.	Most CON standards require review and comment/recommendation from affected state agencies.

A special thanks is offered to all Certificate of Need directors and staff who committed the time and resources necessary to share this information.

Prepared by Thomas R. Piper, April 30, 2006